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ABSTRACT

This field survey relative to adolescent pregnancy was undertaken through site visits and interviews. Data indicated that: (1) while many people are carrying out excellent programs and activities, the numbers are small compared to the need; (2) in some types of services the old tried-and-found-wanting approaches are perpetuated; (3) in some, helping professionals won't help adolescents; (4) certain areas of the country offer very few services in the face of obvious need; (5) there are resources as yet untapped--older people and adolescnets themselves; (6) financial and human resources have not been used to their best potential; (7) media resources have not been used beyond a small per cent of their capacity to affect knowledge and attitudes for healthy change; (8) no national priority for youth and no national policy for youth or the family exists; (9) one of the greatest needs appears to be in the area of interacting and communicating as caring human beings; (10) behavioral research has shown some new facets to human behavior in this rapidly changing society and there are new stresses on youth and their families as a result of these changes. (Author/RF)

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ANALYSIS OF A FIELD STUDY: PROGRAMS, SERVICES, AND APPROACHES TOWARD THE REDUCTION OF ADOLESCENT PREGNANCY

Final Report Submitted to:
The Health Subcommittee
of the
SECRETARY'S ADVISORY COMMITTEE
on the
RIGHTS AND RESPONSIBILITIES OF WOMEN
Department of Health, Education, and Welfare

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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CHAPTER 1. INTRODUCTION

I. SUMMARY OF CONCLUSIONS

This field survey was undertaken through site visits and interviews. It examined programs, services, and approaches that appeared to have valuable elements which might aid in the reduction of pregnancy in adolescents. There is no lack of creative, practical, effective ideas on what can be done and how to carry out a variety of approaches. There are creative, caring, skilled professionals, parents and volunteers who are willing and able to work with adolescents in this area of concern and other related programs and services.

While many people are carrying out excellent programs and activities, the numbers are small compared to the need. Whether we look at recent projections and estimates of need or whether we look at the available statistics on pregnancies of unmarried young women twelve to sixteen, VD rates for adolescents, the number of juveniles in the criminal justice system, runaways, suicides, accidents, school drop outs, adolescent substance abusers, or those with diseases of national note as indicators of unmet need, it is undeniably there and present services are not sufficient. In some types of services the old tried-and-found-wanting approaches are perpetuated. In some, "helping" professionals

won't help adolescents. Certain areas of the country offer very few services in the face of obvious need.

There are resources as yet untapped: older people and adolescents themselves. Financial and human resources have not been used to their best potential. Media resources have not been used beyond a small percent of their capacity to affect knowledge and attitudes for healthy change. Cultural values and human values in the media and our society in general are more often demonstrated negatively rather than positively. No national priority for youth and no national policy for youth or the family exists. Efforts are fragmented, legislation and funding are not coordinated. Laws and regulations are conflicting and in some cases obstructing. Families are troubled and in need of varied kinds of assistance. One of the greatest needs appears to be in the very basic area of interacting and communicating as caring human beings.

In looking at the ideas, philosophies, programs and services, - present, past, or potential, - the observer is struck by an awareness that many of these approaches are not new. Contraceptive technology is new. Behavioral research has shown some new facets to human behavior in our rapidly changing society and there are new stresses on youth and their families as a result of these changes.

II. BACKGROUND OF THE PROJECT

The Secretary's Advisory Committee on the Rights and Responsibilities of Women, through its Health Subcommittee has, as its official purpose the responsibility "to advise the Secretary on health matters concerning women with regard to the Department of Health, Education, and Welfare programs." The underlying concern of the Health Subcommittee is the need for prevention and health maintenance within a comprehensive health care setting for all women.

Through their work of previous years, the Health Subcommittee became deeply concerned with the physical and mental health of young women and was alarmed by the increasing numbers of pregnant adolescents and the attendant problems: the health of the young mothers and their infants; the education of young people for responsible, productive adult roles; and the welfare and stability of the family. Following discussions with key DHEW officials who shared background data reports revealing the increasing extent of the problem, the Health Subcommittee of SACRRW selected the issue of adolescent pregnancy as their priority area of concern for FY 1976-77.

The project chosen by the Health Subcommittee was an overview analysis of the approaches to prevention of high-risk, out-of-wedlock, premature, adolescent pregnancy. The analysis proposed to look at health, education, and social approaches in both the public and private sectors for the purpose of developing recommendations to the Secretary of DHEW. The Subcommittee anticipated that such an overview, based on presently available data and field research, would identify models with successful elements and indicate additional innovative and creative ways in which the issue might be addressed. The Subcommittee determined that the project would also look at adolescent sexual knowledge, attitudes, and behavior, and the psycho-social influences on adolescents with special attention to the culture, family, community education, mass communications media, and the adolescent's self-image and life role expectations.

Two informational meetings were held for the purpose of providing the members of the Subcommittee with additional background information on the subject and for offering an opportunity to the participants to exchange information. The first meeting was held with leading DHEW officials and staff concerned with the issue. Speakers described their activities directed toward the reduction of adolescent pregnancy, their legislative mandates, and funding amounts. A transcript of the meeting covers the

proceedings and indicates the broad range of DHEW offices and programs represented. A second meeting was held for non-governmental organizations and individuals working toward the reduction of adolescent pregnancy. Participants at the earlier Departmental meeting were in the audience.

In October 1976, the Health Subcommittee determined that a field survey of programs, services, and approaches should be undertaken as one part of the overview analysis and requested the U.S. Department of Health, Education, and Welfare to contract with Audrey Moore of Columbia, Maryland, to conduct the survey and submit an analysis of the findings. The objectives of the survey were:

1. To obtain information on programs, services and approaches with the potential to aid in the reduction of adolescent pregnancy with the particular emphasis on primary prevention.
2. To analyze the information to determine the valuable elements in each approach.
3. To draw conclusions about the findings.
4. To make preliminary recommendations to the Health Subcommittee on ways in which DHEW can further the goal of the reduction of adolescent pregnancy.

III. METHODOLOGY AND SURVEY CRITERIA

The field survey was undertaken through site visits and interviews to examine programs, services, and approaches that appeared to have valuable elements which might aid in the reduction of pregnancy in adolescents. The goal was to find enough such elements in existing, recently existing, or proposed models to draw conclusions about what was successful and why. And finally, to develop from these a set of preliminary recommendations for federal action to the Health Subcommittee of the Secretary's Advisory Committee on the Rights and Responsibilities for their consideration.

The survey encompassed a wide variety of settings in many areas of the United States. Primary prevention was the foremost interest, recognizing that while prevention of subsequent pregnancies in adolescence often continued to be important, it was the earlier stage that held the greatest promise for averting the chain of problems associated with premature pregnancy. Programs, services, or approaches were chosen because they met one or more of the survey criteria:

- health, educational, or socio-cultural
- traditional or alternate models
- public or private

- o urban or rural, with target groups of
- o White, Black, Chicana, Oriental, American Indian
- o female or male

There was a special interest in looking at projects aimed at young males because so little has been done in this area.

In choosing a definition of adolescence for this field survey, a variety of definitions and descriptions were considered. Variations seemed to be the result of the many ways adolescents are perceived by adults. A physician specializing in adolescent medicine will define an adolescent as one who is between ten and twenty-one years of age. Legally, adolescence ends in the courts at seventeen and states base their restrictions on driving, drinking, gambling, entering into legal agreements, marriage and voting on ages ranging from fourteen to twenty-one. Age for consent to different categories of medical care has another set of legal limitations, nor are these the same in every state.

One thoughtful, realistic definition was developed by Gisela Konopka, D.S.W. in 1973 at the request of the Office of Child Development, DHEW. Dr. Konopka and the staff at the Center for Youth Development and Research, University of Minnesota came to this conclusion:

"Our view of adolescence is selective, psycho-

social, and goes beyond current existing theories. Central to our concept is this: We do not see adolescence exclusively as a stage that human beings pass through but rather as a segment of continuing human development. We reject the common conception that adolescence is solely preparation for adulthood, except in the sense that everything in life can be considered to be preparation for what follows. We believe adolescents are persons with specific qualities and characteristics who have a participatory and responsibile role to play, tasks to perform, skills to develop at that particular time of life. The degree or extent to which an adolescent experiences such responsibile participation will determine and maximize his human development."

This definition speaks philosophically as well, to the needs of adolescents. It is necessary to be mindful of these needs to determine whether any particular approach or service is really providing something of value to an adolescent.

For the purpose of this survey, the ages ten to eighteen were chosen to represent the period of adolescence of greatest concern. Recent studies have shown that ten and eleven year olds can be sexually involved and some births occurring to twelve year olds.

What is premature adolescent pregnancy? It has been referred to as unintended, unplanned, often unwanted, too-early pregnancy and is usually thought of as occurring to unmarried young women (biologically women, but often in other respects children) still of school age. While this project is concerned with young men, it is most especially concerned with the young women who range in age from ten to eighteen. At the younger ages, ten to sixteen, they are exposed to the greatest risks, physical and emotional, while all are the potential victims of interrupted, often terminated education, abortion, single parenthood, or precipitate marriage. For those who marry under this circumstance, there is an increased chance of divorce within five years. For many young women subsequent pregnancies follow while they are still in their teens, married or unmarried, on welfare or not. Studies show that those who are able to complete their high school education have a better chance of avoiding successive pregnancies within a few years of the first. Those young women who do marry at the time of the first pregnancy or shortly thereafter, often have two or three children by the time they face divorce with little chance for adequate support from either their husband's or own efforts; neither has had the opportunity to develop employable or well-paid skills. The young husbands referred to are those who are also in their teens. The chances are somewhat better for young couples when the

husband is in his twenties if this means he has had the opportunity to develop his earning power. When young women are forced to look for work while their children are infants they have great difficulty in finding affordable day care. This becomes almost impossible with more than one child.

Recent research, studies, and data tell the story in revealing detail. The work of individuals and organizations such as the following has contributed much to the understanding of youth facing these dilemmas. Frank Furstenberg, in his book, "Unplanned Parenthood: The Social Consequences of Teenage Childbearing", 1976, presents a six-year study comparing the life adjustment of 400+ Baltimore girls who became mothers at seventeen or younger to 300+ classmates who postponed childbearing until later. A compelling and compassionate picture of adolescent needs and sexuality, is drawn by Gisela Konopka in, "Young Girls: A Portrait of Adolescence, 1976. The difficult question and some suggested answers, "Primary or Secondary Prevention of Adolescent Pregnancies?" were presented in a paper by James Jekel, M.D. at the Annual Meeting of the American Public Health Association, Miami Beach, Florida, October 1976. Lorraine Klerman speaks to "Adolescent Pregnancy: The Need for New Policies and New Programs," in her article in the Journal of School Health, 45:263-267, 1975. "Approaches

to Adolescent Health Care in the 1970's" Hilary Miller, M.D., BCHS, DHEW, 1975, offers valuable insights; the 1976 publication of the Alan Guttmacher Institute, "11 Million Teenagers: What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States," presents recent data on teenage sexual activity, pregnancies, abortions, and births; "Improving Family Planning Services for Teenagers," Report by Urban and Rural Systems Associates to OASPE/Health, DHEW, 1976; and the not yet released study by James Lieberman, M.D., "Antecedents of Responsible Family Formation," research on adolescent attitudes and why they become sexually active.

CHAPTER 2. CONCLUSIONS

I. UNDERLYING ISSUES

Adolescent pregnancy is not only a national problem; it is first a problem for a particular girl and boy, their parents, and their child. And pregnancy is only one of the problems young people deal with. It ranks along with alcoholism, drug abuse, abuse by parents, failure in school, unemployment and entanglement with the criminal justice system. The larger national issue lies in developing a concern for young people that they become a national priority. It is not only that they are in varying conditions of vulnerability and need; they are the personification of the values of our society.

Adults need help in developing more supportive attitudes toward adolescents, recognizing that the period of adolescence has unique stresses and that period is still within the patterning years. Young people need help understanding themselves, adults, and their world. Communication, honest talking together and understanding, is greatly needed and often lacking. Any programs, efforts, opportunities to develop better communications among people will better serve children and their parents and those who work with them.

Adolescent pregnancy is one aspect of adolescent sexuality and that sexuality is only one part of the total

individual. The individual does not function solely as a sexual being and limited-focus programs will not reach the broader, long-term solutions. Programs, services, and approaches that accept the concept of working with the whole person in a manner that is acceptable to the individual have the greatest potential for successful outcomes.

Ideally, the adolescent should be seen as part of a continuum of the human life span, and thus, ideally, life-enhancing comprehensive services would be freely available from birth to death or at least until the individual is capable of providing for herself/himself. An important reason to look first to "continuous from birth" services, particularly in health and education, is the nature of human growth and development. It is easier to teach beneficial life patterns at the younger age than to attempt to change them later. One of the characteristics of adolescents necessary to achieving independence and making the transition to adulthood is one of risk-taking and a sense of invulnerability. This is evident in such studies as "Sexual and Contraceptive Behavior in Young Unmarried Women," Warren Miller, M.D., 1976; "Sexual and Contraceptive Experience of Young Unmarried Women in the United States, 1976 and 1971," Melvin Zelnik and John Kantner; and "Antecedents of Responsible Family Formation," James Lieberman, M.D.

(not yet released). It is also evident in teenagers' search for adventure, the attraction of challenging exploits, experimentation with altered states of consciousness. Sexual experience is a part of the overall pattern. Many adults drive their cars too fast, ignore seat belts, drink more than they should, destroy their health in the same false sense of invulnerability without the excuse of being adolescents.

This sense of invulnerability in adolescents makes it more difficult to educate for "taking care" of oneself in any area of life. Most young people seen in family planning services for the first time have already been sexually active, usually for a year to a year and a half without using an effective contraceptive method. Many do not know the basic biological facts necessary to protect themselves. The learning and the attitudes need to be developed before puberty.

Until and unless such continuous services exist, comprehensive services for adolescents that provide physical, mental, emotional, and spiritual care are the most desirable in dealing with the total needs of the adolescent. Experience has shown that where adolescents are accepted into a larger, adult-oriented service, as in the health care services, they are relegated to last priority, even where there are specially designated

funds for their care. In contrast, the programs serving only adolescents obviously have that as their primary goal. One of the main differences is that of attitude. People working at all levels are attracted to the programs and stay in them because they want to work with adolescents. In addition, there is no conflict as to who needs the limited dollars more, infants, adults or adolescents. This attitude and effective performance were evident in many types of programs and services: store front free clinics, hospital departments of adolescent medicine, planned parenthood facilities, (for although they are not limited to serving adolescents they attract a young clientele). In some other settings, health programs and services open to all groups in the community, often served teenagers less well and sometimes not at all. Some health workers, including clerical-reception people, set up direct and indirect barriers against adolescents. Some did not want to treat teenagers and either limited the type of service they would give or the teenagers, not feeling accepted, would not return. In other instances, particularly in rural areas where services of health professionals were available only one or two days a week, it was very difficult to set aside separate hours for adolescents and if they were afraid to be seen by adults in a family planning clinic, for example, they did not come.

II. COMPREHENSIVE SERVICES

When adolescents seek help it is for a variety of reasons. This survey is concerned with programs, services, and approaches that either directly or indirectly have the effect of encouraging adolescents to think well enough of themselves to take care in their actions to protect themselves and each other from premature pregnancy. However, by meeting one need there is a better opportunity for meeting other existing needs. Once drawn into a program, whether it has as its primary purpose education, health care, social services, or cultural and recreational experiences, the chance that adolescents can be reached and served in other areas is increased.

The multi-service comprehensive program that can attract and serve adolescents is an optimal approach to dealing with not only the issue of adolescent pregnancy, but other problems and issues related to youth. To be ideal it should be in one building. It need not cost any more than already existing services in separate locations. It needs to have those basic characteristics of any successful program: attractive to adolescents because it is accessible, affordable, confidential and treats the clients with respect, understanding, and warmth. In other words, the staff likes adolescents and believes in their right to all services. It does not need to have

within its walls a full range of highly specialized, expensive services, only timely access to them for some individual clients. It is cost-effective not to have highly specialized services, rather to be considered a primary type of multi-service center. In this way more such centers could be located within neighborhoods for greater accessibility.

Multi-Service Comprehensive Program

There is one program visited that is an outstanding example of what a comprehensive program can be. It offers the widest variety of services to adolescents seen during this survey. It's name: The Door, in New York City. The following services are housed under one roof, run by enthusiastic professionals, funded from multiple sources, and available from afternoon until eleven at night:

- family planning education, services, and counseling
- general health care
- psychological counseling
- legal services
- educational counseling and remedial education; primarily reading - some math
- social services: S.O.S.-"Survival on the Streets" how to find food, shelter, clothing and how to get help from "the system"
- nutrition: a cafeteria and nutrition education

- cultural, experiential classes and workshops offering: music, painting, jewelry making, dance, gymnastics, fencing, yoga, rap sessions on people, values, what's happening in the community
- outreach educational programs in the schools

Young men and women come to The Door in almost equal numbers, sometimes out of curiosity, often out of desperate need. They've heard about it from other young people. They stay because they find something they need or want and then usually go on to take some of the other services offered. Most young women come for the family planning services. Young men may come because they're facing legal trouble and there are free legal services. Others come for the nightly music and dancing. Almost all become drawn into the other services to one degree or another. The professional workers try to get everyone in for a physical check-up along the way.

The physical setting is open; low dividers and furniture groupings creating visible separation of activities in the large main area, walls separating highly active groups such as karate, dance, and gymnastics. And the health clinic with its own lab is completly private, although the lab has a large picture window so that young people can see what lab techs do and at certain

times are allowed to go into the lab and look at their own specimens under the microscope. It is interesting to see a psychologist and a teenager deep in conversation in two comfortable chairs in a small area defined by one low divider and two traffic paths. Several things happen in a situation like this. Others are aware of these two people and don't disturb them as they walk by. Emotional problems, do not need to be hidden. Acceptance and respect for the individual are the philosophy that comes through here and in all the services. One-to-one care is private but not hidden. Group services offer the same caring attitude.

A young woman comes for birth control services, no appointment necessary, but it's a busy night and others are waiting. She joins the small group sitting on cushions near the clinic clerk's desk. The counselor working in family planning education and services joins them and an informal rap session picks up, focusing on the girls' questions and interests. Later, a few young men join them and the talk continues.

It happens frequently that the physical check-ups reveal conditions needing medical or psychological care. A substantial number show no immunizations, others are malnourished, some are hypertensive. They are introduced to the people and services next door, across the

room; everything is within sight. Yoga class becomes part of the regimen for lowering blood pressure. Food and nutrition information is available. Counselors work with substance abusers.

A tense young man arrives. It's his first time at The Door. He heads for the legal services. The lawyer and law student listen to his problem and sense that there may be serious emotional problems also. They tell him they will help him with his legal difficulties and ask him to talk to the counselor next door. The psychologist listens, questions, and appraises him as one in need of immediate care. He appears to be on the verge of some kind of violence or perhaps an epileptic seizure. After a quick consultation with the director, she gives her approval to the plan to get him to the hospital for some tests. With the young man's permission, the psychologist quickly cuts through the red tape at one of the large municipal hospitals to get the tests done immediately and arranges transportation. The moves have been quick and smooth. A practiced, professional team have worked together effectively. They work closely with other institutions and agencies in the city. Often the people they call have worked with The Door before and are ready to cooperate. The teenagers don't get lost in the shuffle. Not only is it comprehensive, it has a high rate of success.

Comprehensive Services in a Network System

Comprehensive services can also be provided by a network system in a community. Minneapolis, Minnesota is exemplary in this respect. The state, with its Scandinavian traditions of community and service to people, supports social services more than many other states, and Minneapolis adds its own special contributions through its people and institutions, private and public. Outstanding among the latter is the Center for Youth Development and Research at the University of Minnesota's St. Paul campus. The Center is a vital resource not only for the state and region, but it has a national impact on educational and correctional institutions, youth agencies, and organizations through its flexible program outreach which includes:

- Consultation with agencies, organizations and institutions regarding program development and evaluation.
- Continuing education and staff development for personnel in agencies and institutions serving youth.
- Resource services for students, scholars, and the wider community.
- Devising models for the active involvement of adolescents in communities through the schools.
- Development of an experimentation with interdisciplinary curricula for people working with

youth, e.g., The Undergraduate Youth Studies Program.

- The Interdisciplinary Faculty - Student-Community Seminar for the regular and systematic exchange of ideas and experiences regarding work and research with youth.
- National, state, and local research projects on specific youth populations, programs and issues.
- Publications which translate existing knowledge into usable form.

In Minneapolis, these are the kinds of dynamic network patterns that can be seen: agency to agency communication; agency to Center for theirs and other University resources; the Center to the agencies and institutions, stimulating, evaluating programs, stimulating new ones. These are some of the results: research is applied by the agencies and institutions, a wide variety of training programs for youth workers are offered and taken and better education and training is stimulated; agencies work closely together in referring adolescents to needed services; agencies, organizations and the Center come together in communication programs aided by radio, TV and newspapers; they work together on legislation to benefit youth; they are effective in getting public and private funding. The Center supports these efforts through their research and programs.

Community based clinics, concerned about the comprehensive health education needs of their adolescent clients, asked for help. Youth volunteering at the clinics, with the assistance of community people and Center staff drafted a community survey instrument. The study, "Twin City Adolescent Health Attitudes, Knowledge, and Behavior," by Jack Korlath, Michael Baizerman, and Stanley Williams, 1976, is available from the Center. The study surveyed about 5,600 youth from high schools in the Twin City Metropolitan Area. The size of the group and relative lack of comparable data about youth make it a major study of its kind. Youth volunteers in alternative youth-oriented medical and health services working with volunteer, professional consultative staff from the Center and the University of Minnesota hospitals conducted the survey. The small budget (approximately $3,000) came from a variety of local agencies, corporations, and foundations. It was a community effort that has contributed to the planning and delivery of health care to adolescents in a metropolitan area.

A short summary of selected findings of the survey is important not only in relation to what is happening in Minneapolis but why comprehensive services are needed.

Health Status:

1. The frequency with which adolescents report having had health concerns of problems within the past year is high.

2. Of the eighteen most often mentioned health problems or concerns, six are related to socio-emotional problems. 47% of the students mentioned concerns about or problems with "depression".
3. The reported occurrence of problems or concerns with personal appearance was relatively high compared to other items listed.
4. Acute pathologies, such as colds, flu, allergies, dental and eye problems were mentioned frequently with 43% of all respondents reporting dental problems.

Help-Seeking Behavior:

1. For actual health problems or concerns, adolescents reported that for 20 of 28 listed problems or concerns they went to "no one" for help.
2. When these adolescents did seek help, they usually went to parents before any other source.
3. For situations related to socio-emotional problems, friends replace parents as the most important source of help.
4. Adolescents say that for hypothetical medical and health situations they would use professional help rather than parents or friends. This seems to indicate that adolescents generally know what to do in seeking help for a given medical

or health problem; yet, when faced with an actual problem, they do not seek (use) professional help. This may reflect a weakness in the health care delivery system or it may be a bias in youth responses.

Recommendations:

1. Any health service designed to serve youth should be comprehensive in nature. That is, it should not be limited to services for problems related to sexuality or drugs. This conclusion is predicated on the reported behavior of adolescents who use differing sources of help for differing health problems.
2. Health services must include services designed to meet the socio-emotional problems that adolescents report they have.
3. In planning any health educational programs, emphasis should be placed on providing information about available health services as well as information about actual health problems.
4. Parents must be included in health educational efforts, since they are the most often reported source of help for actual health problems. Friends or peers should also be included in this kind of effort. It is interesting that these two sources of help - parents and friends - are in many cases likely to be as uninformed

about health as the individual adolescent with the problem or concern.

5. Many of the health problems or concerns adolescents mention are somewhat "sensitive" in nature (e.g., those related to socio-emotional problems, personal appearance, and sexuality); and therefore the context of health care delivery must deal with questions of sensitivity, understanding and confidentiality.
6. There may be an inherent weakness in the health care delivery system for adolescents. It may be that because of the seemingly large number of health problems or concerns reported, adolescence should be viewed, as it increasingly is, as a special category requiring "specialists" in the delivery of health care.

An awareness of adolescent needs in health, education, and other services shows in the Minneapolis network. A drop-in primary care clinic, Teen Age Medical Service, is located in an old house, which looks nondescript and non-medical in a block of other no longer fashionable houses. It is one of the alternate models that started out as a free clinic funded by federal dollars. Now funding is more difficult to get and where a patient can pay, a $3 fee is asked. The service is warm, personal, medically good and operating as much on dedicated, enthusiastic

person-power as hard cash. Many of the doctors, nurses and lab techs volunteer their time. Social workers, clerical aides and teen-agers also volunteer to work in the clinic. Young women and some young men (less than 10% of the total) will come there when they won't go to a traditional medical facility. They keep coming back for follow-up care because they feel welcome, respected and the care is confidential. The clinic sees adolescents ten to twenty years old and they come from all socio-economic levels. Although TAMS is a general health clinic, the greatest demand is for its birth control education and services, pregnancy testing and counseling, and venereal disease testing and treatment. 550 to 600 patient visits take place each month serving 400 to 450 individual patients. The remarkable Dr. Elizabeth Jerome who directs the program can pinpoint the elements which make it successful; a minimal fee, accessible, available service, confidential, good educational materials, but most of all, "your program is only as good as your people. Teenagers come seeking 'self', not just medical care. Who am I? Where am I? They are practicing playing roles. They are looking for many kinds of help, sometimes mental health help and that's not easily reached for. We're in a good position here. When teens have problems we think need other kinds of help we can send them right next door to Walk In Counseling. And TAMS in an out-patient service of the Children's Health

Center, so we have that back up and Northwestern Hospital when needed."

The Walk-In Counseling Center is directly next door and referrals go in both directions. An adolescent has neither distance nor red tape to deal with. It is an important link between a large number of alienated young people and the many traditional services of the county. The Center's free services provide crisis intervention, short-term individual, marital and family counseling, referrals to other professionals or sources of help, public education in mental health, and consultation to other community groups. This last amounts to over 200 organizations which they support in such areas as staff development and program supervision. The Walk-In Counseling Center began in the late 60's when a group of psychologists and graduate students, almost all from the University of Minnesota, contacted the pediatricians at Teen Age Medical Services, who supported their assessment of the need for free counseling services. The Center is now staffed by professional volunteers and supervised by professionals of standing at the University and in the community. It works closely with other organizations and plays a leadership role in identifying community problems and issues.

TAHC, the Teen Age Health Consultant program began as an affiliated program of the Teen Age Medical Service. Although it is located elsewhere now that federal funds which began it are gone, it still maintains a close working relationship with the clinic. Teen Age Health Consultants is the tradename of Peer Education Health Resource's health information program. The Twin City community clinics that had asked for the survey on adolescent health attitudes, knowledge and behavior applied for the original TAHC funding from the National Free Clinic Council, and five clinics, TAMS among them, hired five health educators to develop a program that would recruit and train youth in a variety of health areas and assist them in sharing this health information with their peers. By 1974, the funding was no longer available through the clinics. The health educators incorporated as a non-profit organization and with funds from a foundation and space from Teen Age Medical Services, developed the TAHC training curriculum and implemented the program in three high schools. By 1975, with additional grants from another foundation and the State Alcohol and Drug Authority and the Minnesota Department of Health, TAHC expanded into five senior high schools and one junior high school. Sixty-eight TAHC trainees provided 3,647 peers with health information through outreach efforts.

In 1977, the earlier funding sources were gone, only one health educator, Kathy Jordan remained, and the program was reduced in size. TAHC was operating in one senior high school and funding came from the school for this as a one-time experimental program. When the student TAHC trainees were interviewed, an impressive picture of learning, growth and effective outreach emerged. All those present were young women. They said the young men would come to the training sessions but they hadn't been able to involve them. (Other programs have found that it is desirable to have male counselors to reach males and keep them involved.)

The students are called counsultants rather than counselors to avoid the impression that they are in any way equipped to be "experts" or give therapeutic help. The TAHC program developers were aware that most young people they had worked with were interested and concerned with two areas, their own sexuality and substance abuse, so these areas were emphasized in the training. Students volunteered for TAHC and were taken on the basis of interest only; no special behavioral or scholastic requirements were made. After eighteen training sessions of two-hours each with the health educator satisfactorily completed, the "consultants" went in pairs on their first assignments. They went by invitation to classes in senior highs and junior highs, to a

special high school for ajudicated girls, even to P.T.A. groups to tell about their program. They all said they were nervous the first few times they spoke to groups but got over it and began to enjoy the experience more each time. They even were able to handle hostile questions in adult groups. Their greatest pleasure came from knowing their peers wanted what they could give them and were benefiting from it. As one young woman said, "I was asked by the teacher in the class (after a one-session visit) to come back and teach the six-week segment on sex education. This was a seventh-grade class and the kids looked up to me, being in senior high. After I was there awhile, I could see the teacher was glad to have me, too. She wasn't that comfortable talking about sex. My school gave me released time to do it one afternoon a week and I got credit for it, too. I felt good about those junior high kids and about what I was doing." The other young women present told their individual stories about being a TAHC consultant. Some had opposition from parents initially, but won them over. Another said that when she told her parents about volunteering to learn about sex education, they said, "O.k., o.k. just don't talk about it around us." They all said they wished the boys would join the program because "they needed it." They couldn't seem to get past the embarrassed snickering stage.

Another valuable aspect of the TAHC program was the school's recognition that the learning and teaching efforts of the student volunteers were valuable. This recognition was given in the form of scholastic credits, which the student valued. This attitude on the part of the school is seen in the Action-Learning Project that schools and the Center for Youth Development and Resources are developing together.

Action-Learning is taking place in some of the schools in the area and Diane Hedin is staff from the Center on the project. One participating school is Southwest High in Minneapolis. Both sexes participate equally in this project which offers students the opportunity to work in a variety of settings outside the school with some released time from classes and credit for the work time. Business and industry in the community cooperates to offer placements of an apprentice nature in architect's offices, the V.A. animal lab, a metal foundry, a newspaper, for example. There is an attempt to place students in the work field they are interested in for a future career. One high school junior described her work in the V.A. animal lab. She asked for any kind of lab experience because she thought that was what she wanted to prepare for. The V.A. had never taken high school students in any capacity but after interviewing her at the school's request and becoming interested in

the Action-Learning Project, they accepted her. Now she is in her senior year completing her second year at the lab to the great satisfaction of both employer and student employee. She also believes that it was her work experience that tipped the scales and won her acceptance at college. Students must be able to carry both work and class responsibilities but the combination of the two seems to work well. Some students who were having scholastic or behavior difficulties have worked out both through this project. The general response has been one of greater growth, both in learning and maturity. The students express a great sense of accomplishment and satisfaction. They particularly like being a part of the adult world of work with adult responsibilities. The school carefully chooses the work situations so that they are interesting and productive for the students. Sometimes a student comes to the project director with a special work situation in mind and is helped to develop the interest of the employer to make it possible. One such student was a senior very concerned about rape crisis help for teenagers. She knew that the rape crisis center in her city had no teenage counselors. She asked to work with that organization and be allowed to take the training to become one of their counselors. This was arranged and now not only is she a counselor but she is a speaker to community groups and has developed a working rela-

tionship with the District Attorney's Office and the Governor's Office to develop awareness of adolescent needs and programs. The young man who works in the foundry was the impetus for developing that employer's participation in the project. He loved the metal work he had done in school so much that he wanted to go on and with the help of the project counselor and the school, it was finally accomplished. Actually, there are two counselors. The school counselor assigned to the project and the consultant from the Center for Youth Development and Research who works with the schools to develop the Action-Learning Project. The learning achieved in these work settings goes beyond the cognitive or manual skills. This is another way of learning about self; an opportunity to discover one's capabilities, self-respect, respect for others and from others.

Face to Face Health and Counseling Service, Inc. in St. Paul, has several clinics serving adolescents. One special concern they address is adolescent abuse. In a recent workshop they sponsored on that subject, they brought together other community organizations working with youth to develop more effective means of uncovering adolescent abuse and aiding the adolescents and their families. Those who have worked with teens have learned that adolescent abuse is better hidden than child abuse; the adolescent usually won't reveal it. It sometimes

begins when the child becomes pubescent and in other cases has continued from early childhood. The service workers also face legal dilemmas of state laws requiring them to report abuse which often results in the abusing parent being jailed, the family broken up, and no support for the children. Face to Face is one of the community organizations receiving supportive help from both the University's Center and another private group called The Enablers, Inc. Both, for example, sent staffers to lend expertise in running parts of the workshop.

The Enablers helps youth-serving organizations such as Face to Face to get started, find funds, develop their programs and staff, and work with other community organizations for greater effect. Since 1973 this private, non-profit agency has provided resources, technical assistance and consultation. Perhaps one of the most valuable services they perform is to help new organizations develop funding sources. The Enablers has published a directory of 500 agencies in the seven county Minneapolis-St. Paul area which serve youth (aged 6-25) and covers service categories which include: chemical dependency, corrections, counseling, crisis and phone services, education, employment, food and shelter assistance, health, juvenile justice, legal assistance, multi-service, planning and development, recreation,

residential facilities, sexuality and spirituality. The Enablers provides through their newsletter a communications link for the state focusing on local and state youth related issues such as legislation affecting youth, learning disabilities, youth on boards, juvenile justice, programs for young women, youth and sex, and chemical dependency. It provides information on conferences, workshops, resources, and new youth programs. It does on a state scale what youth service workers in all fields are asking for on a national scale. The Enablers are presently trying to launch a new progr m to take young prostitutes off the streets and provide a protected setting for rehabilitation.

A current two-year project has been established by the Center for Youth Development and Research called the National Youth Worker Education Project. It is a nationwide training program for staffs of organizations serving adolescent girls, including girls with problems, and is attempting to bring together workers in youth-serving organizations and personnel involved in corrections. It is hoped that people in both types of organizations, by working together, can develop coordinated programs, improve their understanding of girls from widely varying backgrounds, and achieve real improvement in services for all young women. This program

represented the first step in an application of a nation-wide survey and study done by Dr. Konopka, Director of the Center, of the needs, concerns, and aspirations of adolescent girls. Both the study and the project have been financed by Lilly Endowment. Dr. Knopka and her staff interviewed a purposive sample of approximately 920 girls, twelve to eighteen years of age, from a wide variety of backgrounds - a significant portion were active in girl-serving organizations, many were not active, and a sizeable cross-section were ajudicated delinquent - to find out what young women of vastly disparate experience want and need for their own best development. The girls represented every conceivable ethnic and socio-economic milieu, urban and rural. The interviews covered areas of common experience and concern, including feelings about school, career expectations, attitudes towards marriage, children and their own families, attitudes towards adults in general, views on sex, and experiences in and opinions about girl-serving organizations.

The trend of the future is that community agencies will increasingly be called on to provide services for "status offenders", many of whom are adolescent girls. Why be concerned in this field survey with "status offenders",

"delinquents"? Normal young girls are very often being labeled "incorrigible", the legal euphemism for sexual activity. Or they may be runaways from an intolerable family situation. Pregnancy is one of the hazards they face and agencies and services other than family planning services will play a role in meeting that need as they attempt to meet others. Juvenile courts throughout the country are moving toward diversionary programs for these much misunderstood young people so that they can avoid often disastrous involvement with the criminal justice system. Youth-serving agencies should be able to serve such status offenders an integral part of their programs. The staffs of youth-serving organizations have the opportunity in this project to develop the skills to work with troubled young people. The Center's program will deal with personnel who will lead in the local and regional development of the expanded and more comprehensive services. The eight national youth serving organizations involved in the study are Big Sisters, Camp Fire Girls, Girls Clubs, Girl Scouts, 4-H, National Federation of Settlements and Neighborhood Centers, Red Cross, and YWCA. Participants from correctional institutions are selected in cooperation with national and state organizations. The development of understanding of the wide range of adolescent behavior and an understanding and tolerance of serious adolescent problems cannot help but aid girls already in those service organizations.

The network of services in Minneapolis/St. Paul is not a formalized system and only works as well as it does because of the calibre of the people involved in each organization and the community as a whole. There are formalized systems within local governments that do not work nearly as well. However, the dedicated workers in the Twin Cities are aware by the numbers of young people showing up in remedial care services or in the statistics on pregnancy, overdoses, court dockets, and suicide, how many are not being reached. The question still remains: how to reach more people, more effectively.

III. HEALTH MODELS

Based on the conclusion that comprehensive services in a particular field are the next best option when a multi-service comprehensive approach is not available, the models offering the most comprehensive health services were found in the departments of adolescent medicine of large teaching hospitals and medical centers and their outreach programs.

Montefiore Hospital and Medical Center, the Bronx, New York, carries out a remarkable program through its Adolescent Program. Begun ten years ago, it has multiple sites offering comprehensive services to young people, capability for studying the issues of health in the adolescent population and using these clinical research laboratories for the education of health professionals in a major health problem area, the health of young people. Dr. Michael Cohen who heads the program described the philosophy of the program: "We look at the adolescent in a holistic way rather than a specific illness pattern. To look at an adolescent with regard to her potential for pregnancy without looking at her for her potential for other risks or pleasures of life would be a mistake. The issue of pregnancy is too narrow. The broader issue must be addressed; nor is it the issue of contraception and all

the types of contraception. That leads only to the family planning clinic. Twenty-five year old women go to a family planning clinic because they're planning families. Twelve year olds don't go because they're not planning families. What is adolescent sexuality, libido, orgasmic phenomena? We lock up teenage girls in New York State for sexual promiscuity. They serve eighteen months in a training school for being sexually promiscuous. We don't know what normal sexual drive is. How can we say what is promiscuous drive? But it still happens legally. Society and the parents see that girl as being incorrigible so the label used is sexual promiscuity because that's the law on the books. We have to plan the programs, the funding, legislation, education research in the much broader base of looking at young people and their specific needs. That's why we have not looked at narrowly targeted money such as family planning money - and it's too insecure."

The Adolescent Program services are free for those who cannot pay and medicaid and third party carriers are used. No federal family planning dollars have been requested. The services include:

- In-patient unit with a full range of in-patient health services, school program, behavioral science, child life program, recreational, and social work. All of the services are offered and all of the training is offered.

- o Ambulatory program including two ob-gyn clinics.
- o Service within the criminal justice system; Spofford Juvenile Detention Center, serving 5,000 detained youth from ten to sixteen years of age, male and female; some affiliation with a state institution; some follow up to the home (LEAA funded); Riker's Island Municipal facility, serving 10,000 to 15,000 men per year, sixteen to twenty-one years old.
- o Addictive illnesses; one-third of the drug abusers are young women.
- o School health. Montefiore used to have an "alternate learning space" (federal dollars now gone) for high school drop outs run jointly by the Board of Education and Montefiore. Doctors, nurses, teachers made up the faculty. Montefiore continues to train school professionals within their local school district, provide physicians for school athletic teams, and provide the health service for Barnard College.

Dr. Cohen's views are that we need a multi-faceted program, and he cited The Door, which will address the major health issues of young people. "A horizontal program offering a broad-based range of activities, within which is family planning. Put it all together and evolve a comprehensive view-program that is more health promoting. We need to

look at all the health-related issues of young people: education, jobs, psychosocial health, legal issues, the environment and old-fashioned medicine. We need to tie them together. One cannot look at Job Corps training in the Department of Labor and not look at health related issues. You can't put ghetto youth into Job Corps training and forget about adolescent sexuality, drug and alcohol abuse, and tooth decay. There does not exist, currently, a central focus for looking at youth related issues."

"Looking at adolescent pregnancy by itself is not seeing the broader issue of adolescent health. The traditional planned parenthood clinic, or v.d. clinic, or well-baby clinic pattern is absurd. It takes the teenagers and shunts them around. If we're going to set up a teenage pregnancy program, let's look at everything, their teeth, eyes, immunizations, nutrition, school failures, psychosomatic illness."

"Whatever programs are developed they must take into consideration the cultural differences. They must be tailor-made to fit the needs of the individual and that community. There are 44 million Americans between ten and twenty years old. 21 million are young women. 21 million teenage girls can't all be packaged together," Dr. Cohen concluded.

Other adolescent medicine departments in large hospitals that were visited were the Adolescent Medical Unit at New York University Medical Center and Bellevue Hospital in Manhattan and the Division of Adolescent Medicine at Children's Hospital of Los Angeles. Adele Hofmann, M.D. is the Medical Director of the Adolescent Medical Unit located in Bellevue Hospital. She is also the President of the Society for Adolescent Medicine and shared some observations and concerns ranging from medical through legal, educational, psychosocial and cultural. She observed that the direction of medical care is changing to include adolescent medicine as a subspeciality. Before this, adolescents were seen as children and were treated in those ways that fit the picture of them as a child. Because adolescents take over from the older generation there is an inherent psychological antagonism between adult and adolescent. To set up a whole separate system for adolescents may not go economically. Yet, the health systems report that came out of the Breckenridge Conference indicated the wide variety of services the adolescent needs. The Door is a model of that health system. Dr. Hofmann said, "Adolescents need something different than anyone else in society. They need to have at least an equal amount to everyone else in society. The adolescent also serves as a model because you can't ignore pieces of health care, it won't work. The concern

of the health care provider for the adolescent ought to be comprehensive, and that has to do with a totality of a response system for his needs: biological, emotional, and social. We should be looking at such issues as access to health care, confidentiality. On describing some of the socio-cultural factors affecting teens seen at Bellevue, Dr. Hofmann discussed the relationship to roles and futures: Puerto Rican girls are first generation born here, with a strong Hispanic culture. They are having great difficulty dealing with the restrictions their families impose on them and the great freedom, by comparison, that they see other young women enjoying all around them. The young black girl who is part of the welfare cycle does not have any future view of her life. If she were to look at it, it would be terribly bleak. She grows up in a poor educational system. She's in the ninth or tenth grade, if she's lucky. She has a fifth or sixth grade reading level at best. There are few enrichment resources available to her in the community. Her parents have never really offered an optimistic view of what will be available to her. She's told that if she could go to college she'll better her life and yet she isn't given the learning skills to get there. It's a Catch 22. She's told there's no other option for her, as are the boys, except to go through an academic structure. And we have 40% unemployment

among our youth, even those with high school diplomas. I can only speak to the inner city kid from my own experience of their view of their futures. I don't think they really dare to think about it very much. We say they're so "now oriented", but if they were to think about it, - what's in store for them, they'd go out and commit suicide. It's a dismal outlook."

In summary, Dr. Hofmann listed a series of needs:

- Treatment and preventive health care.
- Education of the adolescent to the use of the health care system.
- Training of professionals to deal with adolescents, specifically adolescent sexuality.
- Make the "system" easier for teenagers to negotiate.
- Adolescents need help in asking for contraceptives; "askable" health professionals are needed.
- Trustworthy adults that convey that they can be trusted.
- Access to confidential health care on "open" terms and
- A method of financial support for that care.
- On national health insurance: an emancipated adolescent needs his or her own health insurance or a means to direct negotiation if in a family health policy so that confidentiality can be maintained.

- Adolescent health care is more time consuming. A time unit (for seeing the adolescent patient) is two to three times longer to include education, questions, understanding, etc. Third party payors must relate this difference to fee schedules.
- Legislation to allow a minor to consent to certain services. This requires looking at the family unit.
- Establish the right of a teenager to separate from parental domination.
- Adolescent's right to see his or her own helath record in the schools.
- Protection of the health record information as part of the educational record from the parent (Privacy Act of 1974 - HEW guidelines pertaining to health records.)
- Open sex education in schools.
- Look for ways in which society could come to value the adolescent as they did in the past; to value the adolescent for who he or she is in the structure. That means to create roles, turning to them a little out of respect for their abilities and not seeing them as just an extension of childhood. Looking for ways, in communities, in which you incorporate them. Seeing

that they have a valid role in working toward solutions in those systems that they are involved in; that they participate, for example, at the decision making level in schools.

- Involve industry in developing apprentice programs for teens coordinated with basic learning skills. There are many kids who need a work role and need to be helped to live up to that.
- Find ways in which adolescents can have some control over their own lives. They will probably be better able to be more responsible.

At Children's Hospital of Los Angeles, the Division of Adolescent Medicine has as its Medical Director, Richard MacKenzie, M.D. He talked about services and special programs in the Division, how they see the adolescent, and how they try to reach the adolescent more effectively. A new program begun in January 1977 (HEW funded) is directed to young men and the male's role in contraception. The underlying concept is "responsibility for your own health" and dealing with sexuality not in isolation but as a part of total health. Other outreach approaches use verbal and non-verbal messages to attract and involve. A message may be superimposed on a light-show screen with a rock music background. Growth groups for adolescents are conducted dealing with adolescent needs. The staff conducts educational programs through

health fairs and girls and boys clubs. They have an uncommon program component for a hospital, a camp outside the city called YGAD, Youth Give A Damn, a weekend retreat to develop responsibility for one's own health care. It's a place to work together, talk together, sort things out and look at values - Issues are discussed: macho image, contraception, abortion, bonding behavior, etc. Adolescents present questions and they and the nurses, physicians and others on the staff exchange ideas.

This health model at Children's is a medical model which, while hospital-based, is attempting to come closer to a "wellness" approach rather than the more traditional "illness" context. These professionals are not waiting until a sick or pregnant adolescent appears in the clinic but are successfully drawing healthy or near-healthy young people into one service or another, health, educational, or social, to convey the message of total health and individual responsibility for health with the health professional as friend and helper in that process.

Valuable elements of the adolescent medicine programs seen were: the delivery of a broad range of medical services with the addition of educational and social services to varying degrees; broad experience with large numbers of adolescents and a history or research and

training that brings many highly trained and experienced personnel into the services for adolescents; the ability to work closely with other institutions and agencies that affect adolescents, e.g. schools, detention centers, special projects in the city, and city government; the capability to produce special programs within the hospital and through outreach efforts that enhance the basic medical services and by their successes are magnets for attracting additional funds for adolescent projects. Through all of this, a great deal more is learned about adolescent needs and services.

Their size, which is advantageous to all of these elements, is also a disadvantage in those instances where teenagers are too overwhelmed and intimidated to find their way into this system. While the adolescent medicine programs attract highly qualified and dedicated personnel they occasionally have to deal with the rotation of medical, social work, and other professional students through the department, some of whom don't want to be there.

Martin Luther King, Jr. Hospital, Los Angeles, is in the Watts area, serving a predominantly black urban population. This new hospital is the area's center for health care, with strong components in ob-gyn and family planning. County health facilities are the core of this care and

operate out of MLK, Jr. The hospital is associated with Drew Medical school. There are forty-three junior and senior high schools in the hospital's service area and the deep concern for the adolescent population is shown in the variety of services designed to reach young people.

Dr. William Cary, who heads the ob-gyn department, speaks with great concern about the 50-60% pregnancy rate among the high-risk group in that area. They experience a 32 per 1000 perinatal mortality rate and to help combat it, operate an in-hospital prenatal care and education program five days a week serving a large adolescent clientele. A Teen Age Clinic for preventive and primary services was begun in November, 1976 in an attempt to get more teen agers to use the health services. It's a one day a week clinic for adolescents under sixteen and includes social services offering complete evaluations for the entire family. The clinic is looking for an outside location that is less formidable in order to attract more young people.

For the past three years MLK, Jr. has had Carol Smith, a nurse-midwife, working with their teen program and community education programs out of the ob-gyn department. One is the Family Life Program for ages eleven

to twenty which works with the continuing education schools for pregnant teens. This program is given in one semester and covers pre-natal, post-partum information, newborn and infant care, and parenting, with a variety of professionals giving the instruction. In another type of family life program, the nurse-midwife has worked with 80% of the 43 schools to date in teaching the one-week module on human sexuality. This deals primarily with feelings, experiences, and values clarification. Family planning is only one part of the program. Although this is a very brief exposure to human sexuality topics, it is a beginning and is a program effort that is in the building process. This is a co-ed module that encourages interaction with the help of adult facilitators. Next year the program will be expanded by teaching teachers to do it with the support of community health workers. Another in-service training program will develop teams of teachers drawing from social science, health, and biology teachers to provide sex education courses in the schools. This is a one-shot deal using state consumer education funds. The hospital community health workers are actively trying to reach parents and grandparents to help adolescents, many of whom are dependent on a grandmother. They are also trying to make condoms available in more places,

as with physical education teachers, school nurses, and counselors. In describing the seriousness of meeting the health needs of their adolescents, MLK, Jr. staff people say, "The key issue is survival. We are dealing with life or death issues for many of our teens."

Grady Memorial Hospital in Atlanta has a large family planning program which makes a special effort to serve adolescents. Grady is affiliated with Emory University and plays a large and active role as the Regional Training Center for Family Planning. The Director of the hospital's Family Planning Program is Robert Hatcher, M.D. The program holds one evening clinic a week exclusively for teenagers and sees teenagers at all other clinic sessions also. A high percentage of adolescents come to the clinic for contraceptive care, even if they have to travel some distance, because of the low cost and the generally good manner in which they are treated. Counselors and health workers ask for their reactions to the care they receive and act on them. This is a huge municipal hospital serving a large urban population, mostly black. One of the special programs serving very young women is the Interconceptional Program, monitoring the health and contraception of twelve to sixteen year olds who have been pregnant. Nurse practitioners

train in Grady's Family Planning Program and are used very effectively there, providing much of the education to adolescents as well as direct health care with physician back-up.

Other health models, not hospital-based, which were surveyed and found to have successful elements, had a different character to their operation. While less comprehensive in their health services (they referred clients elsewhere when necessary) they tended to achieve closer rapport with the adolescents, often involving them as volunteers or part-time paid assistants in the overall running of the clinics. Many teens had a sense of "belonging" and being needed in a responsible position. This was seen in the Teen Age Medical Service and The Door, both described earlier in this chapter under section II, Comprehensive Services. Adolescents present a paradox; they are a basically healthy population needing a broad variety of services. Clinics and "care" centers like the two just mentioned and Walk-In Counseling Center in the same section, aim at the most pressing needs of so many teenagers, sexual concerns and self-image. These health care models were not fully comprehensive but were holistic. Mind-body is comprehensive health. Mind-body-spirit is holistic health. One of the successful elements in these exemplar programs was

the ability to reach and nurture the spirit of the adolescent. These have also been termed alternate services since they differ from the traditional or usual medical models. They are foremost, informal in their atmosphere. Health professional and client meet as people offering mutual respect in a warm physical setting. The operation is designed to be low cost and to serve people who might otherwise not come into "the system". Therefore every act is calculated to attract and to keep those who need care. This is the philosophy and M.O. of the walk-in clinics, storefront clinics, the Free clinics.

If the circumstances are such that one of the best available health services to reduce unwanted adolescent pregnancy is a family planning service, then the following should be considered for their valuable elements.

The Los Angeles Regional Family Planning Council Inc., with Bill Daniel as Interim Director, is the largest provider of organized family planning services. It is an umbrella organization with a $10 million budget coordinating a network of facilities encompassing numerous health care and education agencies, ranging from local health departments to public and private hospitals and community clinics. Services are provided

either free of charge or at minimal fees, depending on the individual's ability to pay. Some of LARFPC's agencies serve people on a walk-in basis. Evening and Saturday clinics make services more convenient. No parental or spousal consent is required. Community clinic services range from family planning exclusively to comprehensive health care. The LARFPC agencies offer services at nearly 100 locations throughout Los Angeles County and serve a wide variety of ethnic groups in an urban setting.

The Council receives and channels funds to its provider agencies from HEW and the California State Department of Health and acts as a health management and planning organization. Some of the agencies which participated in the survey, Pasadena Planned Parenthood, Martin Luther King, Jr. Hospital, and the TRI-C Community Centered Classroom Project are described elsewhere in this report.

The Young Male Project in Family Planning was begun in 1975 by LARFPC and ran for approximately a year and a half before funds ran out. Its object was to cut down out-of-wedlock pregnancies, venereal disease, and to promote sexual and parental responsibilities on the part of young males. Russell Rhodes, LARFPC's Director of Program Operations worked closely with the project. He

described it as having accomplished a great deal in its short life span and being valuable enough for a continuation funding which was not available. Out of almost 3,000 young males contacted through some 200 workshops, seminars, speaking engagements and rap sessions, 673 young males came into the project.

Salient features of the program included:

- Serving the project city's poverty pockets, which are characterized by the typical high unemployment and high school dropout rates for young men in this age group.
- Enlisting the cooperation of agencies in the geographical areas to be served, with emphasis placed on those already involved in programs with teenagers and those providing special services to teenage mothers. Such agency cooperation was a keynote to the success of the project.
- Using a street work (outreach) component to allay community suspicion about the nature and purpose of the project and to encourage referrals to participating agencies.
- Providing individual and peer group counseling to involve young fathers in the program and to aid them in working out their own solutions to

such tests as current emotional problems, attitudinal relationships with the mother of the child, vocational and educational goals, legal problems and responsibilities.

- Emphasizing factual information on human sexuality, contraception, veneral disease, human reproduction and general health care.
- Utilizing an informal communication network on an inter-neighborhood basis, to provide potential participants with information on project locations and telephone numbers.
- Establishing an effective referral system to provide ancillary service--vocational, employment, health, legal, etc.--to program participants.
- The formation of an advisory committee of program participants composed of eight to ten male participants from each of the project areas. Committee members reviewed educational and promotional materials; provided feedback information on program effectiveness; suggested exploratory areas for the project; and served as a sounding board on issues affecting the direction and effectiveness of the program.

- Training project staff at the outset of the program with factual information on human sexuality, contraception, and parenthood.

The Planned Parenthood clinics visited were outstanding for their type: specializing in birth control services and related educational programs. The clinics surveyed were in large metropolitan areas and selected for their special programs for adolescents. The Planned Parenthood Association/Chicago Area, had as its director, Mary-Jane Snyder. Donna Shavers, Director of Youth Services and Satellite Clinics, and Darrel Hale, Male Education and Outreach Director discussed programs and approaches designed for adolescents. Teen Scene is a special program begun in 1970 and through their five Teen Scene Centers, has served over 25,000 teens with information and education, "rap" sessions, individual and group counseling, pregnancy testing, related medical examinations, birth control services, venereal disease testing, and referrals for other problems. The Male Motivation Program, begun in 1971, recognized that not many males were thinking about birth control services but a lot had sexual concerns: old ones about v.d., masturbation, homosexuality, impotence, and new ones out of VIVA, Ebony, and Ms. that their girlfriends are reading, - "Am I satisfying my girlfriend?" The program starts with these concerns in "rap" sessions and

information programs and adds physical check ups; sexual health as part of total health, is the message. Discussions of sexuality develop to include male responsibility for contraception. There are other program approaches that encourage teens to bring their girl friends/boy friends to "rap" sessions so couple-communication can develop for more effective contraception. These sessions are informal, the setting is an attractive room furnished living-room style with comfortable chairs, cushions and rugs in bright colors. Counselors and facilitators, male and female, help answer questions, stimulate discussion, and generally keep it moving. The program staff emphasized the great importance of having male counselors working with the young men and said that without them the young men didn't really get involved. This was one of the successful elements of these programs, the attention to the human dynamics of using the right personnel to reach teenagers, and developing outreach tactics to appeal to that group; going into schools and neighborhood centers with music, films, live performances. One of their films produced with teenage actors and actresses is a highly entertaining drama ala soap opera style showing how an uninformed teenager progresses from petting to pregnancy, complete with nasty brother and shocked parents. PP/Chicago Area serves an urban population

that is black, white and hispanic and works to meet the needs of the different cultural backgrounds. It has also worked with another special group of male adolescents from late 1973 to early 1976. These young males were a part of the statewide program of Aid to Youth Development. The AYD program was a division of the Illinois Department of Corrections and was primarily for young men who were ex-juvenile offenders or status offenders. This group ranged in age from fifteen to nineteen and was led by a specialist in male education. Each of the forty sessions included a film discussion on methods of contraception, and an open discussion on any topics related to sexuality and family planning. A questionnaire designed to test "Attitudes of Adolescent Males Towards Abortion, Contraception and Sexuality," in this group was ultimately given to 1,017 males over a period of two years. The findings of the study indicate possible trends in changing attitudes that would be very helpful in planning new approaches to human sexuality education including values clarification.

Planned Parenthood, San Francisco/Alameda and Planned Parenthood Marin are carrying out a variety of programs for adolescents, their parents, and parents and children together. They see in the Bay Area an increasing in-

cidence of teenagers living completely on their own. In wealthy neighborhoods such as Marin County, families are fragmented. They see women giving up their mothering much earlier, for example. Teenagers have nowhere to be, they're non-persons with no important role. One of the staff used the expression "adolescenec is obsolescence," and this at a time when puberty begins earler and adolescence is prolonged.

As counselors, trainers, facilitators talked, they expressed the concerns shared in other urban settings: no one uniform project will do it, we need a multi-fold approach. In some places the school is a good place to get sex information; in some places it's the worst. We want to use the media but not if it backfires - arouses the wrath of parents. If Stevie Wonder wrote a good song, it would do more that most public service announcements. Look at the popularity of "Baby Let's Wait" and "Love Child". We need to find ways to reinforce and support young men's sense of caring and responsibility for young women. 7 million men (the recent estimate of sexually active adolescent males) are not in "the formula". Men are 50% of the population responsible. (Actually, if 7 million out of 11 million sexually active teenagers are male, they are more than half of that population.)

The Planned Parenthood staff described working with the Neighborhood Youth Corps who told them which stores, pool halls, and other meeting places to canvass to reach teenagers. The aim is to draw them in, involve them in taking part in their own destiny, futures. In Oakland, the Oakland Male Clinic holds rap sessions on sexuality, relationships, feelings, attitudes. One of their successful elements is the male college students who are skillful in leading the groups. They find that young people exhibit a tremendous desire to know how to do it, they're into being graceful and skilled. They are very receptive. Across the Bay there is the San Francisco Teen Father's Program at Mt. Zion Hospital working closely with a small group, five to eight, of mostly black teens twelve to sixteen years old. They show no feeling of connection with their child, no idea of who they are. Making a girl pregnant is one of the few things they can do. It's creative. They say they don't feel connected but they have ambivalent feelings. They come to the program mostly because of the facilitator; someone is interested in them. The facilitator makes a tremendous effort to keep contact with them.

In discussing ways for getting men into family planning, Planned Parenthood (Bay Area) staff saw the need for

total social service settings in addition to health clinics, and in health components, giving other medical services and including services related to sexuality. There is a need to talk about sexual problems before discussing birth control. Clinics have an opportunity to counsel young men coming in for pre-marital blood tests. Start with what men need and then incorporate family planning, was their preferred approach, as it was in the Chicago Area PP. This approach was evident at one of the San Francisco Health Department Centers which is described later in the section on health departments.

The Planned Parenthood of Marin has several special programs. One is their Parent Program, six in a series, designed to help parents be more effective sex educators of their children. In addition, there are special workshops given such as an all-day workshop for mothers and daughters on human sexuality and the dynamics of communication about sex. PP Marin uses local resource people from university and college human sexuality programs. A wide variety of special services for men include discussion groups on sexuality and birth control, the opportunity to accompany partner through the entire contraceptive visit (if both partners agree), and community education and professional training and

male sexuality and roles. These services are given to encourage men to be contraceptors themselves, utilizing methods like the condom and vasectomy, to be more supportive of their partners for more effective contraceptive behavior, and to develop an increased sense of responsibility in their role in preventing unwanted pregnancy.

Pasadena Planned Parenthood Committee, Inc. has been conducting classes since 1974 on human sexuality for parents, teachers and youth workers. It is given in Pasadena and Sierra Madre by Jane Murphy, M.A., M.F.C. and is one of the few courses of its kind open to the general public in the Los Angeles area.

Rocky Mount Planned Parenthood in Denver is known nationally for its production of excellent educational materials as well as the usual clinic services. Sherri Tepper, the Executive Director, shared some of the activities she and the staff have as their priorities: working closely with their physicians, nurses, and other health workers to keep the costs as low as possible while offering the widest variety of contraceptive services and counselling, for example, moving toward the newer mini-laparoscopy when physician training in this technique is completed and it can be carried out

as an office procedure. One of their priorities is reaching teenagers and they have placed their Lakewood Center in an area near several schools with a high school population in need of services. This determination of need grew out of a cooperative working relationship with the Jefferson County Board of Education's health education and family life program people. Their exceptional program is described in the section on education programs.

The Planned Parenthood associates around the country have a great deal of autonomy and while their general purpose is the same, programs and funds vary considerably. They share in the advantage of being able to buy as a national group, quantity purchasing lowering the costs of supplies and enabling them to set low fees. Adolescents are encouraged to pay part or all of the regular posted fees wherever they can and most do. The PP centers seem to have certain advantages over public services. They can and do move into controversial areas working to change restrictive community attitudes. Some centers spend a great deal of effort in outreach programs for teens, using the media and sending their staff into schools, community centers, and parent groups. With their diversity and autonomy they, like some others in the private sector, provide variety in approaches to

birth control services that are not so easily achieved in the public sector.

Health department family planning services for adolescents seen in this survey were mostly related to pre-natal services for pregnant young women. In this context, the Maricopa County Health Department in Phoenix is one trying to reach teenage women with birth control information and services before pregnancy but the large proportion of their efforts last year went toward serving the more than 2,600 pregnant school-age young women who came to their pre-natal clinic. Many came from other parts of the state, which is predominantly rural. Health Departments in these areas say they don't have problems with pregnant adolescents. Perhaps it is because so many prefer to take a bus into Phoenix where they are met by a sympathetic team of doctors, nurses and social workers. For most, family planning information comes after a pregnancy and is secondary prevention.

In the City and County of San Francisco Department of Public Health, Health Center #4 operates the largest county-sponsored family planning program in San Francisco. It has recently added a Men's Reproductive Health Clinic at the Mason Street location. It was

opened October 1976 with an HEW grant. This grew out of a pilot men's clinic in Hospitality House, a neighborhood center where the Health Department had operated a small satellite clinic for the women's family planning clinic one afternoon a week. Some of the men there suggested the need for a men's clinic. The new clinic is offered one night a week and is free to San Francisco residents. Media coverage has been good and that and referral and work-of-mouth have accounted for a good client response. In the first four months they had seen 250 men. At that point 60% were in their twenties and 5% were teens. The clinic staff speak English, Chinese and Spanish. They serve white, black, Latino Native American, Japanese, Arab, Indian, Pakistani, Italian and Cambodian men. The Men's Clinic includes health education and counselling; general physical exam, medical screening and referral; diagnosis and treatment of sexually transmitted diseases; VD testing and referral; information, counseling and referral for vasectomy; and free condoms. They are new and working to reach more men and eventually to offer a partner's program at the clinic. Their aim is to provide a "hassle-free" non-judgemental atmosphere.

Mary Lane, M.D. was Clinical Director of the Margaret Sanger Research Bureau and during the period February 1971 to March 1973 conducted a program for teenagers at the Teen Center, a separate service for adolescents seventeen and younger. They measured the success of the contraceptive program not in the number of clients provided with a method but how many attained the results they came into the program to achieve - usually maintenance of a non-pregnant state - and how many adhered to a prescribed schedule for follow-up. Using these criteria, the program was very successful. Of the 404 young women cared for at the Teen Center in the two years, there were only ten who experienced pregnancies. Six of these were method failures (all IUD). The drop-out rate (meaning no response to follow-up) was only 8% even though the Teen Center was not a neighborhood clinic and many clients had to travel more than an hour by public transportation after school hours in order to get there. The low pregnancy rate, the high rate of effective contraception, was apparently due to the outstanding <u>support system</u> which they considered essential to the success of any program of contraceptive care for teenagers. This was a well-developed, well-maintained support system which served to strengthen the clients own potential for being an effective contraceptor. It included identification of those factors

which may be interfering with the fulfillment of this potential.

Although the method selected should always be tailored to the client, the central issue was giving the client a method that took into consideration the elements operating in her daily life which hindered or supported her use of it. In describing the support system, Dr. Lane continues:

"The essence of contraceptive service for a teenager, in our opinion, is that quality of service which says to her: adolescence is a normal stage of your life; you are a normal person, not a sick kid; your social experimentation and your difficulties in making decisions are to be expected; your interest in sex is natural; the anxieties you feel, the dilemmas you face, the inconsistencies and contradictions you experience in your thinking are not unique to you. You hold them in common with all other normal maturing girls, and because they influence the way you use your contraceptive method, you need to examine them.

It also says to her: you need to decide why you are not using your method well and why you are feeling tempted to stop. You may even need to examine the reasons you are having intercourse in the first place;

or whether or not what you really want is to become pregnant. You need to identify and examine your own sexual feelings and attitudes. All this is essential, and the mechanism through which all this is done is the support system."

The young women were supported by:

1. Peer group process
2. Staff TEAM approach
3. Volunteers (also teen clients)
4. Partner
5. Parent(s)
6. Repeated contact
7. LOVE

Dr. Mary Lane feels that not all teenagers will participate in or even require, the sort of support system described. But for most typical teenagers, some system of continued support is part and parcel of good care and is necessary for successful results. Other individuals in the field, such as Dr. Elizabeth Canfield, interviewed later, say that Dr. Lane has had equal success in helping young adolescents achieve effective contraception with the diaphragm, which many physicians shy away from prescribing in the belief that adolescent women are unlikely to use it in a responsible manner.

IV. EDUCATIONAL PROGRAMS

In trying to categorize the types of educational programsseen, it becomes quickly evident that there is a great deal of cross-over between categories. This is as it should be because successful health programs, social service, youth service, and certainly multi-service programs have educational components as one of their major successful elements. It is difficult to think of any of the programs, services or approaches surveyed that aren't educational in some aspect.

Those that are primarily educational are:

- university centers for teaching, research, and resource development
- public school programs for training teachers and educating youth
- family planning clinics outreach and in-house education programs
- action learning and youth participation programs
- programs training health professionals and paraprofessionals.
- health spots and health specials on radio and television
- values clarification program

Two vital university centers seen were at Syracuse University and the University of Minnesota. The first is the home of the Institute for Family Research and Education. Sol Gordon, Ph.D, is the Director of the Institute, psychologist, and author of many books on human sexuality and education. The Institute is especially interested in encouraging effective communications between parents and children for the strengthening of the family. This concept has been broadened to include others working with children and the family so that workshops are regularly given for parents, teachers, clergy, counselors, social workers, health professionals, and volunteers working in the helping services. Annual workshops on human sexuality have been held since 1970. The Institute produces many books, publications, and tapes on sexuality, adolescents, substance abuse, parenting, techniques for leading group discussions, and books for children and adolescents, including some comic book formats for sex education for the non-reader.

Dr. Gordon shared his vast network of fellow workers in the field and some of his thoughts on sex education: "Sex education is a lifelong process that begins in the home and continues in the school, the media, and the community. It remains a learning phenomenon throughout the life cycle. Let me state that I do not favor sex

education courses per se. They may be necessary until such time as all of us have been educated and can respond in a reasonably mature manner to sexual issues. More often than not, sex education in the schools consists of courses in plumbing, or what has been called a relentless pursuit of the fallopian tubes. A much more rational approach would be the inclusion of sex wherever appropriate in all aspects of the curriculum. Some of the best opportunities for such inclusion would be in health education , social studies, psychology, and home economics classes. The best sex education takes place in the context of responsible values and decision-making, whether it is taught in a course or in the context of a private session with a counselor."

"I suspect too that once we get over the national misconception that sexual knowledge is harmful we won't be too far away from good sex education in the schools. Extremist opposition to sex education is often based on the irrational idea that if you tell children about sex they will do it. The fact is that mature sexual behavior is positively correlated with sexual knowledge."

"I do not have any doubt that the most important progress in the area of sex education will be through the influence of the women's liberation movement. Self-fulfilled, educated women do not accept the double

standard perpetuated by insecure men. Here too, counselors have a responsibility, in their 'power' roles, to eliminate sexism by encouraging women to strive for equal educational and career opportunities and to pass around the rumor that the double standard is dead."

"In order to get yourself ready for the real sexual revolution, here are some principles you might like to think about. The six 'freedoms' explained below are taken from the 'Bill of Sexual Rights," which was developed by myself and Syracuse University's Student Committee on Sexuality (1973)."

A Bill of Sexual Rights

Freedom from Sexual Stereotyping. Cultural definitions of masculinity and femininity are the key to sexual stereotyping. Our culture has insisted on the idea that men should be aggressive, worldly, strong, rational, and dominant and women should be passive, domestic, weak, emotional, and submissive. The destruction of these stereotypes is necessary to achieve honest human relationships of any kind. We have also been led to believe that heterosexual love is the only legitimate and 'normal' kind of love. We must recognize that homosexuality, bisexuality, and other sexual behaviors are also valid. We must also guarantee a person's right to reveal or not to reveal sexual interests and tendencies.

Furthermore, we have to break out of stereotyped views, new and old, about marriage and living together, recognizing both as healthy arrangements for two people who are in love. We also need to become open to unconventional pairings, such as an older woman with a younger man, elderly couples, and interracial couples.

Freedom from Sexual Oppression. The exploitation of women for the purpose of selling products and services reduces women to sexual objects and creates narrow, stereotypical standards of beauty. Women are also exploited as workers, being underpaid for most jobs and receiving little recognition on all levels - economic, educational, social, and sexual.

Freedom of Information. Access to basic information must be guaranteed to all, regardless of age, sex, or intelligence. In the case of mentally handicapped people, special efforts must be made to give them the information they need in a way that they can understand. Freedom of information should also include the right to read pornography and other literature that has not been subject to societal restrictions. Only complete freedom of information can ensure an educated populace.

Freedom from Research Nonsense and Sex Myths. Access to accurate information is crucial to a healthy sexuality.

Unfortunately, not everything in print is reliable information. One 'study' reported that males were 'in their prime' at age eighteen, females, in their late twenties. Popular reports like these and even more reputable studies often confuse a person's commonsense approach to sexuality. Some research is extremely valuable (Masters and Johnson's cures for sexual problems, for example), but popular articles on sex in magazines and newspapers actually create new myths. We must find a sane perspective on research based on common sense and basic facts about sexual behavior.

Freedom to Control One's Own Body. We must be free from legal sanctions in the control of our own bodies. This freedom would prohibit legislation restricting medical abortions, voluntary sterilization, consensual sexual relations among adults, contraceptive information and devices for minors, and privacy of sexual expression. Also implied is the right to choose one's own life style and sexual partners. Inherent too is the right to proper medical care and access to contraceptive devices for anyone who wants them.

Freedom to Express Affection. Until we overcome our fear of expressing our affection for one another, regardless of gender, we cannot achieve full sexual adjustment. Our culture now suffers great anxiety about even touching

another person - hugging, holding hands, and so on. We must be able to feel free to touch another person, even a member of the same sex, without fear of critical diagnosis and fixation. This is especially important for children, who want and enjoy physical affection from adults.

Sexual Responsibility

Although these freedoms are a necessary precondition for healthy sexuality, they are not without their corollary responsibilities. These moral or ethical standards also must be commonly accepted:

- o No one has the right to exploit another person's body, commercially or sexually.
- o No one has the right to suppress information about sexuality.
- o No one has the right to spread venereal disease.
- o No one has the right to exploit children sexually or to take advantage of mentally or physically han icapped people.
- o No one has the right to impose his or her sexual preferences, including when and with whom to have sex, on anyone else; sexual choices must be voluntary.

"These freedoms and responsibilities cannot be guaranteed by any constitution but will evolve gradually as people's

consciousness about sexuality changes. The most important factors in effecting this change will be a willingness to communicate openly and to explore preconceived notions about sexuality. A facilitator in this process will be complete access to information."

The Center for Youth Development and Research, University of Minnesota, with its involvement in a broad variety of areas, has been described previously in this chapter in section II, Comprehensive Services. Gisela Konopka, D.S.W., Director of the Center, is a pioneer in the study of adolescents and perhaps nowhere is there a more accurate and poignant description of the feminine half than in her book, "Young Girls - A Portrait of Adolescence." From her vantage point of many years of working with young people, she shared some of her observations and philosophy: "Sex is not a totally separate drive; emotionally it is part of the creative urges. There is a wide range of normalcy in sexual behavior and we need to get away from labels and categories in dealing with adolescents who are, as a group, normal and healthy. We should be seeing sex as a part of a whole yearning, burgeoning of curiosity and creativity. If we don't help provide other outlets they will go to sex. Young people need many outlets. They need significant adults in their lives. They need some

adults who are easy to talk to, to discuss problems, ethics, the meaning of life, not moralistic preaching. It is so important for young people to be able to develop caring relationships. You know, violence and abuse are strongly linked to sex - always have been. Young people need safe places to stay, without paying for it by having to accept psychiatric counseling - baring their souls - or the judicial system. That is often the alternative for runaways. There is violence within families and where can young people escape to? We need to be able to treat families. There is a need to focus on adolescents because not enough people care about them. Young children have more advocates."

"There are so many reasons for pregnancy after the biological reason; adolescent curiosity, excitement, exhuberance. And of course they need information, first about 'understanding ourselves'-educating for social situations. That's critical in day to day living for the young person. How to talk to a friend, boy or girl. People come together in action, so let's do it in terms of action. How do you get into situations? How do you deal with situations? Facilitate communication everywhere it's needed. Add sex education as another part of human interaction and let's have co-ed groups with the opportunity to separate on occasion. In all

of this, this is where we need those 'significant others'. Any help that is given in the spirit of friendship is the help that has the greatest impact."

"The mass media, especially TV, could be used in a helpful way. Show gifted people enjoying excitements that young people can have other than sex. Not that we want to avoid sex but sex should be shown with affection. Let adults talk honestly about all the things they did and enjoyed when they were kids. Open the doors of the world to the kids. Get them into the theatre, music, art, print their literature, enable them to perform. Bring artists into neighborhood centers; artists in residence, creating, young people watching, joining in, creating, developing their imagination to see what is around them. Give them opportunities for dance - partially drama - to express self, to be seen. Let's have the genuine input of kids so that they are really participating. I'd like to see young people in films on TV being interviewed, recognized for their work, art, etc. Young people need adventure, travel. Why not youth hotels and subsidized travel?" Returning to the topic of services for adolescents, Dr. Konopka said "Night services are needed too, but services are given according to the comfort of the adult."

Some of the programs and "adventures" for young people Dr. Konopka hopes for are happening in a relatively small way now and are noted later in the report.

An exemplar human sexuality education program in a public school system was found in Jefferson County, Colorado. Grades 1 through 12 each received some aspect of education for human sexuality appropriate to their level of understanding. The youngest classes begin with feelings. Children are encouraged to express their feelings, to talk about being happy, sad, fearful, angry; how they feel about what happens with parents, siblings, playmates, how they feel about themselves. This begins the base for awareness of feelings, one's own and others, and later learning integrates factual sex information with feelings and values. At the intermediate and upper levels the human sexuality components are placed in different subject areas in the curriculum. The program starts with the premise that those who teach and those who administer must all be comfortable with teaching about sex in their classes, in their schools, and fully committed and suportive of the program for it to work. The central planning, training and direction comes out of Health Education and Family Living and Don Shaw is the coordinator for the program.

The human sexuality education program grew slowly and carefully with the utmost care given to two vital areas: parent-community involvement and acceptance, and the training of the teachers who volunteered to teach the classes. These teachers were screened first to determine their level of comfort with their own sexuality and teaching others about sex. The selected group were then taken through a training program to work on these areas before dealing with how to teach the curriculum. The administrators were included in this type of training when their schools were selected, one at a time, as community acceptance was gained. No child was compelled to take any of the sexuality components. A parent could request that the child not attend but very few made the request. At any time a teacher changed his or her mind about continuing, withdrawal was made easy for them. A team of teacher-coordinator, nurse, and administrator was designated in each school to act as support to the teachers giving the courses and to be alert to any indications that a teacher might not be teaching at the desired level needed for that course and might need help. If for example, a teacher was going through personal problems, a life crisis perhaps, the team would be there to help or get help, or arrange for another teacher to take over temporarily or permanently. The school system is very

concerned that this course have the teachers best able to teach the spirit as well as the knowledge content. The reception from teachers, parents and students has been very good. One of the delicate areas the planners are now wrestling with is that of child abuse. How far do their responsibilities go? It's very possible that young children who are usually feeling afraid or guilty themselves in such a situation may have an opportunity to release these feelings with trained teachers. One of the teachers going through the training session was able to talk for the first time about her own early experience as an abused child. She expressed the pain of keeping it suppressed for so long and wondered how many children now in her school might be suffering as she had and how long it might be before they were able to receive help.

An earlier experience with a public school was described by Virginia Satir, teacher, social worker, and now a family therapist. She is often referred to as a pioneer in family therapy. For six years, beginning in 1951, Virginia Satir worked with a high school in Franklin Park, Illinois (near Chicago) when the school was anticipating growth from 200 students to 2,000 in 4 years and was planning to make certain changes. She developed a program that was going to be multi-faceted

to upgrade learning and motivate the students so more would go on to another level of education after leaving high school (most went to work or got married; only 2 or 3% went on to higher education), and give the students more of what was called preparation for living. Results: increased to 50% the number of students going to college; diminished the pregnancy rate almost to zero; and the emotional health of the students was very good." This is what she did: "By the time the kids get to be 10 or 12 and into puberty they're going through some crisis periods with their families. The school gets them in a state of confusion. This is a marvelous time for some well-integrated teachers to begin to be some role models for these kids". Satir worked on this principle plus the principle that education also included preparation for living. "I chose the English department to be the vehicle for family life education and I put it on the basis that really good living was related to good communication. I took it out of the province of Health and the school nurse. The health teachers would come in and take part in it. We got some nice physical education programs out of this. I took the English teachers and taught them family life education. We broke it down so that the first year emphasized body processes and sexuality and material on learning how families develop. The students were

developing all kinds of feelings about their parents. They learned about inter-personal relationships, friendships, and that relationships don't always have to be sexual. We worked on their self-esteem, and then we increased that in the second year showing all kinds of ways of being interpersonal so that boy-girl relationships didn't only mean sex. I introduced lots of touching so that people could be pals with one another and I brought in all kinds of people from the community to just share - not do, but share. Now in the third year, we started something we called 'Preparation for the Family' - for your own family. In the fourth year it flowed out of what had been going on. Six weeks of every grade level in every English class was spent on this. Not only did I take the responsibility for teaching all of this but I also picked the teachers with the highest kind of human quality: full of fun and zesty people I thought had good sexual relationships themselves and could have fun together. The teachers really got into this and we invited parent groups to come in. (The teachers got released time to do this.) We would share with the parents what was going on. Then we'd have the kids come in. We were meeting weekly for awhile. What we were doing was building a connection with the parents and the kids and the teachers. It really worked well. We really made a connection a

beautiful triad; and support was built up. One of the biggest problems for teenagers is that they don't have a good heterogeneous support system. Many feel isolated from their parents so their peers are the only ones they have and their peers are often quite ignorant, lovely but ignorant. And the teachers often feel disoriented and unconnected with the families. The teachers met with me regularly once a week. The data was easy to come by but I taught them how they could connect. During the four years I went into every class once at least, sometimes twice and we played. We did stuff with boys and girls together, and lovely things happened. That was what was happening in family life - life preparation education."

"Now, we would also prepare for the new students coming from eighth grade into our four-year high school, and their overall curriculum needs. Starting in January, we would go into those eighth grade classes and a teacher from the English department would meet with a student and his parents and his eighth grade teacher. They took a tape recorder along and they talked about what they all hoped for in his education, what kinds of classes were available, what the student wanted to learn. They did that with everybody and went back to the high school and built classes around that. This was a public school but they didn't have a set curriculum. The person who

met that student, his family and his teachers, became his adviser all the way through up to college, became his guide, shepherding him through, not calling him in and saying "Now you didn't get this or that grade," but became a real friend. There was continuity with the advisors. Discipline problems dropped; all kinds of things happened. There were beautiful relationships with all these people; we were building. I picked these people for their zestiness. It was a group of lovely people. The few paranoid ones got out. A few others we upgraded. Each of these teachers had thirty students. As the school grew, I drew in other people. The so-called counselling group was not part of the mainstream of this but they were adjunctive to it. I kept it on an educational level instead of putting it over into mental health. We had all kinds of beautiful things going. Physiology got incorporated into this-into the English classes so that it was like you were carrying out communication at the highest level of all the things that had to do with what was going on."

"We also had a resource box, question box, stuffed with all kinds of things the kids wanted to talk about, find out about. It was all in education, any and all questions. Then the kids would ask to come by and talk individually with me about some of these questions."

"This program offered something stable for the community. It offered a support system for teachers, for kids, for parents. The education was blended; it was total education. The whole level of knowledge was tremendously increased." (The program went for ten years to Satir's knowledge) "This was a working class, Catholic community. The parent got a lot of education too."

Maude Parker was Director of one of the most interesting school programs and perhaps the one with the longest title: Family Living and Sex Education Student Peer Information Project. It took place in fourteen New York City public high schools from 1973 through 1975. This was a student originated project and took extraordinary determination - three years of effort - to bring it to fruition. The idea for the project originated when a group of concerned students, dissatisfied with the education they had or had not received in schools and believing that students have a right to non-judgemental information, enabling them to make informed decisions regarding their own behavior, formed "The Student Coalition for Relevant Sex Education." This group, representing students from all over the city, contacted students, teachers, parents, and community members and got 9,000 signatures supporting their idea for peer sex information and referral center in each

city high school, and petitioned the New York City Board of Education for such a project. It was a long uphill struggle to gain the support of parents, teachers and the Board of Education, but in 1973 the Board did approve the development of a peer sex information project (which was the title the students gave it) as an adjunct to the existing sex education curriculum. The students and the Bureau for Health and Physical Education worked together to request funds from several foundations for released teacher time, a training staff, and materials. The Ford Foundation gave them a grant to implement the project in fourteen schools on a pilot basis. In discussion with Maude Parker, the program was highly successful in several ways: the students used the service, participated as information-givers, and learned and grew from the experience. All the painstaking groundwork for gaining acceptance from parents and community representing diverse ethnic and cultural groups is detailed in the annual report of the first year 1974-75 available from the Board of Education. The greatest obstacle, however, turned out to be funding. One of the interesting sidelights in this process of meeting with parent groups to show them what would be taught was the parents' requests for classes in sex education for themselves. In the course of the project valuable manuals were developed in English, Spanish,

chinese and Greek Many of the students were immigrants or first generation born here. The greatest obstacle turned out to be funds for continuation of the project. When the Ford Foundation funding ended, the Board of Education did not assume the additional cost.

Maude Parker, nurse, teacher, and former supervisor of Family Living/Sex Education Programs for the N.Y.C. Board of Education has written and excellent article, "Black Identity: A Sensitive and Sensible Discussion of Sex Education for Blacks in the Central City," which appeared in the November/December 1974 issue of School Health Review. She says, "Sex education should facilitate self-understanding, self-acceptance, and rational decision making about one's sexuality. Black students in the central cities need the type of sex education that incorporates the positive concepts of the black image, history, and cultural variations . . . a gestalt of black awareness in their sexuality. Self-knowledge about one's sexuality, self-appreciation, and decision making skills are essential to survive as a black person in a society where legal and social sanctions limit the full expansion of the potential of blacks. Sex education for black children should be geared to prepare them to cope realistically with the future and still maintain a positive, hopeful, healthy outlook."

"Parents who understand that the curriculum will not be just a narrow 'pelvic centered' one, but will provide for consideration of issues of daily living and decision making and valuing for the future, without usurping the individual or family values, will themselves become awakened to their own needs for some type of sex education. So many of the black parents in our black communities requested adult sex education classes that our Family Living/Sex Education Citywide Advisory Council elicited the assistance of staff educators from local health agencies. The School Assistance Task Force of Planned Parenthood of New York City provides teacher, student, and parent education, not just in conception control but in the broad context of sexuality. Metropolitan Hospital and Coney Island Hospital have organized programs for parents of all ethnic groups. Governmental cut backs in funding have severely limited this parent-school-community type family living/sex education cooperative venture with many agencies in our city."

"The Operation Total Family of Harlem Hospital with its team of educators and health assistants led by Celindia Carroll, director, has developed an effective as well as a cognitive educational program for the parents. They participated in developing the film 'A Matter of Choice' especially for the central city population.

They developed several handbooks for adults; their handbook, 'Man, Sex and What's Happening,' is designed for the target population of the Harlem males. This effective team provides an anthropologized, community-wide program that should be duplicated by others."

The Youth Values Project is being administered by Population Institute, with Susan Ross as the Project Coordinator. The project is designed to look at adolescents' sexual attitudes and values and also to determine which media teenagers "consume" and what new ways media can be used to reach teenagers with sex information, including birth control. In June 1976 the one year project was begun by selecting a group of 22 teenagers, 14 to 18 years old, representing a cross section of New York City youth to work on the several aspects of the study. They were project staff and paid for their work and participation on an hourly basis. Their first job, with Ms. Ross' help, was to develop a questionnaire to be used with a large sample group to determine how teenagers feel about sex and birth control. When those were returned and analyzed, the teen project group participated in weekly discussions on attitudes and values. The group permitted this interviewer to sit in on one of their afternoon sessions last March. The young men and women had come to know

each other in the nine months they had worked together. They had shared many feelings, building a base of sharing and trust. They talked about how much they had learned about each other and themselves and how their attitudes had changed during that time. Some of the young men told about the feelings of not being part of their peer group when they were virgins and being taunted for "not getting any," not being a man. Some of the young women in the group were single mothers of infants and living with their parents, some were pregnant with their first child and unmarried, and the rest had no children. All talked about boy friends pressuring them to have sex and the feeling that if they didn't their boyfriends would leave them. One young woman told of her shock and dismay at discovering how much work a baby was and how changed her life was. She thought "it would be peaches and cream", that her mother would take care of the baby and she would be free to go with her friends. She said, "My Momma makes me pick my cotton! After school, I have to take care of my baby, wash his clothes, feed him, put him to bed, and stay in evenings doing homework. I don't get out much at all now." Her friend in the group sitting next to her, and who was pregnant, listened but said nothing. One of the young men said, "I feel very responsible for

the girls I'm with. I don't want to get anybody pregnant. Before these talks, I didn't realize having a baby was so hard on the girl." The group talked about weighing the costs (immediate - the "hassle") of using contraceptives against the future costs - the possibility of pregnancy. Included in some teens attitudes against using contraceptives is fear and the belief that they are "bad for your health" - "give you cancer and blood clots". This group did not believe that and felt they were better informed than their friends who had not been in the group. In talking about those peers they said, "The do sex versus nothing meaningful to do." And about jobs: "I'd like a job I really enjoyed. I didn't use to think that was important. I thought nobody enjoys work." At the end of this discussion session, several young men and women said they would be sorry when the project was over. They had learned a lot and wished other teenagers could have this kind of group.

An educational program that is advantageously affecting rural clinics in some areas of the country is being given to women who want to be Women's Health Care Specialists and have the offer of placement in a family planning clinic. The intention is to place as many of these specialists in underserved areas as possible. Two variations of the six-month training program are

given. One is for R.N.'s and one for non-R.N.'s who are high school graduates. Both learn to perform two-hand pelvic examinations, give basic family planning, ob-gyn care and be able to recognize conditions that need to be referred to a physician. There training programs are being given at the Universities of New Mexico, California, and Oregon. Irene Gurule, Director of the Taos-Rio Arriba/Community Action Program Family Planning Services, says this has meant a great deal to the small rural clinics in that two-county area. It has enabled them to stretch their clinic capacities at less cost.

Tri-C, Community Centered Classroom, is a group of alternate classrooms, located in off-campus facilities throughout Los Angeles. It is an option designed for students who have been expelled from the Los Angeles public schools. Lori Manasse, Ph.D., Director of the program, referred to the sex education component taught there, that it had been a key to opening communications with the students and working toward respect for self and others, reading and critical thinking, and helped toward developing positive behavior.

Teen Age Health Consultants (TAHC) is the tradename of Peer Education Health Resource's health program described in detail in section II, Comprehensive Services. It is

an educational program that falls into the special category of action-learning and deserves a second short description. Action-learning programs are educational for those involved in them and in this case educational in their service output, reaching other teens with sex information. In other types of action-learning programs, sometimes called youth participation programs, the service output may be a social service for others. Some of these are described in the following section. The teenage health consultants found that in the act of sharing their knowledge with others a tremendous amount of self-esteem was developed along with the cognitive learning.

V. SOCIAL SERVICES AND PROGRAMS

Youth participation projects come in as many shapes and sizes as the adolescents and their interests. They have in common action-learning, learning by doing, and usually getting as much as giving - getting in terms of learning not only "things" but learning about others, themselves, their ability to work, share, make responsible decisions, and in the process, gaining an improved image of themselves. The self-image, self-esteem, is one of the keys to the ways an adolescent functions, handles daily situations, even makes decisions about sex and contraception. Self-esteem means feeling the self valuable enough to take care of.

In this sense, youth participation projects provide a "social service" to the young participants. In another sense, the young people usually give social services to others. In either case they are valuable ways of introducing adolescents to some of the excitement of discovering themselves.

Judge Mary Conway Kohler is a woman with experience and wisdom who shares this excitement with and for young people. She is the Director of the National Commission for Resources for Youth and formerly a New York City

juvenile court judge for over twenty years. The Commission was formed in 1967 by a group of social scientists, educators, and businessmen to promote programs which would give young people an opportunity for experiential learning while they performed valuable services for their communities. The Commission began by identifying and validating those already in existence. It has collected more than 800 examples of such innovative programs. They have published several excellent resource books on what, where, and how: "Youth Into Adult - Nine Selected Youth Participation Programs (1974); "New Roles for Youth In the School and the Community"; and they publish a newsletter on new programs called "Resources for Youth", which was developed as part of a grant from HEW.

The Student Coalition for Relevant Sex Education in New York City, described earlier, was one of these projects. One program visited in San Anselmo, California is called Switching Yard. Cathy Howard, Director and Tim Stanton, former Director described a recent project which was the Children's Social Activity Program. High school students, in pairs, led small groups of elementary school children with mild social and emotional problems in structured after-school play - therapy activities. The student group leaders also attended weekly training

meetings run by Ms. Howard and Mr. Stanton. The high school students began the program when they recognized the need and brought it to the attention of the adult staff at Switching Yard. Projects like this start as short term, one semester or two in length so that students can plan, work and complete a project within the school year. There is a goal and a sense of accomplishment possible within a relatively short period. If a project continues to be valuable and can be continued by new students if the originators have moved or graduated, it is.

Other programs in other places have taken adolescents into service projects in nursing homes for the elderly, "Teens Who Care" in Adams, Minnesota learned how to give individual therapy to handicapped children. New York City teens have done murals on buildings. Child care projects in day care centers have shown what it means to care for a small child. Students also learned something about human sexuality and parenting. Georgia high school students were the ones who rescued from the bulldozers, artifacts of a 2,000 year-old Indian culture. Many school systems are using some form of action learning programs. A large number exist in Minneapolis and St. Paul.

A totally different program has the common ingredient of being experiential. It is both educational and social and takes place in the Rocky Mountains outside of Denver. It is the Wilderness Experience Program, Youth Improvement Program/Jefferson Action Center in Denver. Claire Brown, Ph.D. is the Executive Director of this non-profit organization offering a program to youths eight to fourteen. It is a unique attempt to encourage the development of skills which assist children, including those with special needs, in understanding self, relating to others, and becoming more aware of personal creative potential. In summer, children backpack high into the Colorado Rockies where they discover a remote, novel and energizing natural world. In winter, children explore the snowy slopes through the skills of snow shoeing and ski touring. Children work closely as group members, reflect upon their effectiveness as wilderness companions, and experience a deeper sense of self in relation to the physical and social worlds aroung them. Wilderness Experience also has a professional training program for adults in the fields of education and mental health and a consultation program for schools and youth service organizations. The organization, started in 1971, is funded by charitable organizations, foundation awards, and federal grants for innovative projects. The Jefferson County Welfare Department also refers economically deprived children to the program.

The Breckenridge Outdoor Education Center in Breckenridge, Colorado is described by the organizers Randy Collins and Gene Dayton as, "an alternative, adaptive program and activities research center which employs experiential education techniques to minimize the handicaps of disabled persons and to maximize the opportunities for disabled and able-bodied persons to serve one another in reaching a common goal of attaining higher levels of awareness. The adaptive outdoor experiences in a wilderness setting are designed to build self-confidence and social integration. They are based on the Wilderness Experience Program and the National Outward Bound School.

The Wilderness Experience Program ends with fourteen year olds, the Breckenridge Outdoor Education Center provides for the handicapped, and The National Outward Bound School is probably too expensive for most adolescents and their families. They are mentioned here because the concept and the potential are not only valuable but too exciting to be ignored. Even high-powered executives are going to wilderness programs to discover their untapped self. Here is adventure, challenge, risk, self-reliance, cooperation, decision-making, everything we say adolescents need.

Based on the experience of the twenty-eight National Outward Bound Schools in the world (six in the United States) the outcome from such programs are:

A. Affective. The student becomes more willing to:
   1. attempt untried experiences
   2. open self to others
   3. accept responsibility for own actions
   4. cope with discomfort and stress
   5. more aware of limits of personal abilities

B. Interpersonal Communications
   1. student tries to resolve conflicts with others
   2. tries to speak honestly of his/her feelings
   3. spends time talking with others about things that deeply concern him/her
   4. shows concern about another's feelings
   5. is willing to try another's ideas and/or adopt their plan of action
   6. willingly recognizes other's achievements

C. Improved Group Interaction Skills
   1. student becomes more open, is willing to try another's ideas and/or adopt their plan of action.
   2. increasing willingness to carry own weight, do mundane tasks,
   3. to accept responsibility of leadership
   4. increasingly involved in the group process,

problem-solving, decision making

5. good teamworker, maintains positive relations with other members of the group
6. shows improved spirit, joy and tone

D. Increased Environmental Awareness and Responsibility

Family Power of Maricopa County in Phoenix is a consortium of social, educational, and health organizations working together to improve services to families and children. Ms. Hila Jo Swiger is President of the organization and also Director of the Y.W.C.A. Represented are the Phoenix College Adult Family Living Program, Planned Parenthood, the Prevention Division of the Department of Corrections, the clergy, and other sponsors from the community. Together they find they have more impact in effecting community action.

The national service organizations for youth have not been described in this report although their contribution to youth development is widely recognized. It was not possible at this time to survey the large numbers of organizations in the depth they deserve. Many have shared with us their increased efforts to work with young people in the area of human sexuality, family life, and parenting. National representatives of these organizations participated in the information sharing meetings and informal discussions held by the Secretary's Advisory Committee on the Rights and Responsibilities of Women.

VI. PSYCHOSOCIAL AND CULTURAL ASPECTS

A field survey of programs, services, and approaches such as this cannot be a definitive report on all the psychosocial and cultural aspects affecting adolescents and their families. It can however, share some of the experience of the people interviewed and point to some directions for further exploration.

The American society, unlike those in most other countries, is not a homogeneous one. Standards acceptable to one group are not acceptable to another. The most common experiences to all groups come through national television programs, radio, advertising, and films; perhaps even in that order. This is not to say that all people incorporate all such messages into their lives in the same way or to the same degree. Nevertheless, the mass communication media, particularly television, is the greatest single agent for change in our society. Newspapers, magazines, books, play a more subtle role and for a smaller segment of the population. Today's most effective messages are delivered with great impact. They are instantaneous and graphic, requiring little intellectual effort. The messages are insidiously pervasive, abrasive, seductive, and come in all the colors of the brightest fantasies, including the sexual. In

fact, they build heavily on the sexual. Media messages from multi-national merchants say, "Have it, get it, do it, you need it. 'It' will make you handsome, beautiful, smell good, more desirable, noticed." The hidden message is, "You are not good enough as you are. Shine in the reflected power and glory of the Phantasmagora Fast Front!" The GNP goes up and so does the adolescent pregnancy rate. Certainly there are other influences at work. Media producers interviewed very rightly point out that what is shown is only a reflection of what exists in society. However, the control of content and style seems to be narrowly constructed. That youth are affected in many ways by the media is accepted although "whom, by what, and how much," is still to be determined.

What are the cultural influences affecting youth and families in our society? Rapid changes in most areas of living occurred with improved means of transportation and communications in an expanding economy after World War II and a generally improved standard of living which enabled many Americans to buy, travel, change jobs. Many moved from rural areas to metropolitan areas. Urbanization with its high density populations and problems brought other changes. Workers moved wherever the job opportunities were. Families no longer had

their support systems of relatives and friends. Adolescence became even more prolonged as technology grew and their services were no longer wanted. This has been referred to as the "inutility of adolescence." Academic, and particularly scientific programs were stressed in schools over the vocational. Apprenticeship programs declined as unions moved to protect wages and jobs of adult workers. Present unemployment further reduces jobs for youth.

The adolescent receives conflicting messages about sex in this society. As he or she experiences the great energy of physical and intellectual growth, and the excitement of these changes, society says "you are too young". In trying to protect the adolescent or deny their sexuality, the message may be, "It's not right for you to have sexual feelings." Yet the teenager is surrounded by stronger messages and examples of sexual freedom for everyone else, or so it seems.

Adolescents today have difficulty in meeting many of the normal needs of adolescents. It has never been an easy time but it is even more difficult now. It is also a difficult time for parents. They have problems of frustration, alienation, loneliness, and if adolescents have been called the "now generation", their parents qualify as the "me generation"; what is

going to make me happy. Rapid change has also meant greater acceptance of change, one of the corollaries being, "if you don't like it, change it" - or even "leave it". Divorce and desertion rates climb as the stigma is removed from divorce and the mobile society swallows up the deserting parent. Adults are alienated from other adults, adolescents are alienated from adults. The inability to communicate well for satisfying personal relationships, both within the teenage generation and between teenage and adult generations, increases the tendency toward a narrow individualism, "to do your own thing", and above all, achieve a certain detachment, unruffled, as in being "cool", "mellow", or "laid back" - really pleasurably out of it.

Adolescents need warmth, affection, friendship. They need acceptance from others as an O.K. human being. When that happens, whether through the development of a skill in sports, art, work, or service to others, when it is received and believed, it can become part of the adolescents' self-image and healthy development.

In 1973 the office of Child Development, HEW, published a small but beautiful document about adolescent youth in the cultural context of the United States of America in the 1970's. It was prepared from discussions with Gisela Konopka and people of various backgrounds,

disciplines, and ages and titled, "Requirements for Healthy Development of Adolescent Youth". The objectives were:

- o to present a positive developmental model of adolescence by describing what we regard as the key concepts and qualities of adolescence;
- o to set forth some of the conditions for healthy development of adolescent youth;
- o to discuss specific obstacles to such development.

The cultural context of the document set out a number of specific attributes of our culture considered to be particularly relevant to the statement on the requirements for healthy development of adolescent youth. There are two that have been quoted to serve as the closing paragraph.

Human Rights

Ideologically, ours is an open, free society based on the proposition that the purpose of government is to advance and protect basic human rights. Those rights are presumed to be inalienable - that is, natural, irrevocable and nontransferable. Society is obligated to create the conditions under which human rights can be secure. Among those that we believe lie closest to the healthy development of youth are:

- The right of the individual to be himself, to think his own thoughts and to speak them, consistent with the rights of others;
- the right to grow and to develop his abilities to their full potential;
- the right to air his grievances and to seek redress;
- the right to make mistakes without unreasonable punishment;
- the right to justice.

What course society will take in the 1970's with respect to supporting the basic rights of individuals and groups remains to be seen. We assume the direction will be positive.

Human Responsibilities

The enjoyment of rights carries with it the obligation to take responsibility. In our society, concern for one another with alertness toward handicap-producing circumstances is a basic human responsibility. Informed decision making is also a basic responsibility, since roles and opinions are not authoritatively prescribed.

CHAPTER 3. RECOMMENDATIONS

I. RECOMMENDATIONS

1. Make youth from birth to twenty-one years of age a national priority.

2. Focus on youth through:
   a. An Office of Youth within DHEW with the authority and funding to coordinate all services, programs, research, and funding for youth.
   b. A National Organization for Youth to act as an advisory body to government on the above areas. This organization should be comprised of representative youth under twenty-one and non-governmental institutions, agencies, societies, and individuals of all disciplines and interests related to youth. It should be funded equally by federal and non-federal funds.
   c. Coordinated planning for all services related to youth recognizing the specific needs of the adolescent.

3. Design new approaches to encourage improved education in school systems and their participation in all coordinated systems changes to benefit youth such as:
   a. Grants for training professionals and paraprofessionals who work with youth.

8. Increase apprenticeship opportunities for youth.

9. Aid communities to develop community or neighborhood multi-service centers including primary medical care with family planning services. Build into the structure guarantees for adolescent services. Design the legal framework so that community consumers and providers share responsibility for planning and managing the centers. Include adolescents among the consumers.

10. Fund all health care for youth from birth to twenty-one years of age through both public and private services to maintain and encourage variety and innovation. Wherever possible encourage adolescent services in existing facilities.

11. Create a national clearing house and communication center for information on youth: data, listing literature on youth, research, new projects, successful existing projects, literature (indexed, cross-referenced, sufficiently described), resources, legislation, agencies, and funding sources. Collect data by year age for more meaningful analysis of youth-related statistics.

12. Identify and evaluate as many valuable leaders, programs, services and approaches as possible in a continuing effort.

13. Use the people who have valuable programs, services, and approaches to advise government policy makers and agencies.

14. Use these people to give assistance to others who want to use their models.

15. Make obvious the valuable things that are taking place.
    - o Publish a regular, frequent, national information sheet that describes what's being done.
    - o Fund videotapes of programs and cassette tapes for circulation to people who want to start programs.
    - o Fund prime time on national television to show people and programs.

16. Develop substitute living situations for young people who cannot live at home.

17. Develop day care facilities for infants and children within communities.

18. Encourage programs serving adolescents to include adolescents in their decision-making processes.